Appendix 7

Medicaid Guidelines and Performance Measurements for Child Care Coordination

The following pages provide guidelines with which child care coordination (CCC) agencies are required to comply when providing CCC services. The document is divided into four sections:

I. Child Care Coordination Administration.
II. Family Questionnaire Administration.
III. Care Plan Development.
IV. Ongoing Child Care Coordination and Monitoring.

Benefit guidelines are listed in the left-hand column of each page, while performance measurements are in the right-hand column. Wisconsin Medicaid uses the performance measurements to determine if the provider is complying with the benefit guidelines. If a guideline is not met, the provider is required to have written documentation that it has a reasonable alternative in place.

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I. Child Care Coordination Administration

GUIDELINE The provider must:	PERFORMANCE MEASUREMENT
I.A. Develop a plan which addresses the hiring and ongoing support and training of staff who can provide quality services that are family-centered and culturally appropriate.	**I.A.** The provider's plan to hire, support, and train staff to provide services that are family-centered and culturally appropriate must be documented and available for review. Documentation of staff training includes the name of the employee, date of training, and the employee's signature.
I.B. Develop and implement an outreach plan to inform potentially eligible pregnant women and families with newborns (eight weeks or younger) about the availability of CCC services. At a minimum, the plan must: • Identify the provider's target population (for example, teens only, all eligible families in the county, families in specific ZIP codes). • Outline the strategies that will be used to inform eligible recipients, the local community, social service providers, schools, local health care providers, and other appropriate agencies and organizations about the availability of CCC services. Outreach efforts could also include community presentations, informational brochures, posters, billboards, television ads, or newspaper articles.	**I.B.** The provider is required to have an outreach plan available for review. The plan also must be specific to the target population and address strategies to inform eligible pregnant women about CCC services.
I.C. Establish written procedures to ensure that care coordinators include recipients, to the full extent of their ability, in all decisions regarding appropriate services and providers.	**I.C.** Written procedures that meet the stated guidelines are available for review.
I.D. Develop and implement internal policies and procedures for ensuring that quality services are provided in accordance with Medicaid rules. At a minimum, these policies and procedures address: • Patient confidentiality. These policies must include clear statements regarding the type of information that can be released, the time period for which the authorization is valid, and the agencies or individuals to whom the information can be released.	**I.D.** Written policies and procedures that meet the stated guidelines are available for review. Documentation of all activities that meet the stated guidelines is also available for review. Provider records indicate paraprofessional supervision every 90 days, at a minimum.

GUIDELINE (I.D. Cont.)	PERFORMANCE MEASUREMENT
• Accuracy, legibility, and completeness of records (for example, the accurate scoring of Family Questionnaires, the legibility of care plans and other written information, and documentation of all contacts with, or on behalf of, a recipient). • Procedures to ensure that priorities established in individual care plans are addressed in a timely manner. • Procedures to ensure that recipients are offered services that are sufficient in intensity. The procedures must include well-defined criteria for increasing or decreasing the intensity of services. • Procedures to ensure that timely and appropriate referrals are made and there is follow up on all referrals. Unless otherwise stated, follow up on referrals must be made within two weeks of the referral. • Ongoing staff training and support, including adequate supervision and support of paraprofessionals. Provide face-to-face supervision of paraprofessionals every 90 days, at a minimum. • Appropriate staff-to-client ratio. Ensure that care coordinators have an adequate amount of time to spend with each family. The number of clients per care coordinator will vary depending on the needs of the families on their caseload. • The provision of services by culturally competent staff. • The provision of services that are family-centered. • Procedures to ensure that staff are following the provider's policies and procedures for the provision of services. The policies and procedures must clearly identify: • The staff responsible for oversight of the policies and procedures. • Steps for prioritizing, monitoring, and correcting problem areas.	

GUIDELINE	PERFORMANCE MEASUREMENT
I.E. Develop written procedures and policies for determining when cases are to be closed (for example, the recipient no longer lives in the county, or the recipient has accomplished all identified goals).	**I.E.** The provider has written procedures and policies for determining when cases are to be closed.
I.F. Establish written procedures to ensure that a qualified professional reviews and signs all assessments completed by paraprofessional staff.	**I.F.** The provider has written procedures requiring the review by and signature of qualified professionals for all Family Questionnaires completed by paraprofessionals.
I.G. Develop a written plan for providing timely, non-disruptive, translator services for recipients who are hearing impaired and for recipients who do not speak or understand English. If the provider does not have an interpreter on staff, the provider must maintain a current list of interpreters who are "on call" to provide interpreter services. Do not use family members as interpreters when administering Family Questionnaires or for the initial care plan development. Do not use children as interpreters.	**I.G.** The provider has a written plan that meets the stated guidelines available for review. If the interpreter is not a staff member, the agency has a current list of "on call" interpreters available for review.
I.H. Develop written procedures for scheduling recipients for the initial assessment, initial care plan development, and for ongoing care coordination and monitoring services. The schedule should allow adequate time with each individual to address her problems, develop a plan of action, and provide information, if necessary. If possible, schedule the initial assessment within 10 working days after the request for a service or after receiving a referral. The procedures must also include guidelines for staff regarding the time frame within which the initial contact must be scheduled after the Family Questionnaire and care plan are completed.	**I.H.** Written procedures that clearly outline the provider's plans for scheduling the initial assessment, the initial care plan development, and ongoing care coordination and monitoring services must be available for review.
I.I. Develop written procedures for following up with recipients who fail to keep appointments (care coordination, social service, medical or other appointments). Include time frames within which the recipient must be contacted and the steps designed to help the recipient keep future appointments.	**I.I.** Written procedures that meet the stated guidelines are available for review.

GUIDELINE

I.J. Maintain a current list of appropriate community resources (for referral purposes). The list includes, but is not limited to, the following services and agencies:

- Adoption.
- AIDS/HIV.
- Adult protective services.
- Alcohol, tobacco, and other drug abuse.
- Child welfare services.
- Children with special health care needs program.
- Day care centers.
- Domestic/family violence.
- Early childhood intervention programs (for example, Head Start, Birth to 3).
- Education.
- Employment/job training.
- Family planning.
- Food pantries/other food services.
- Special Supplemental Food Program for Women, Infants, and Children (WIC) programs.
- Housing and shelters for the homeless.
- Legal assistance.
- Social services (e.g., family/marriage counseling, family support services, clothing for newborns).
- Parenting education (including fathers).
- Perinatal loss/grief counseling.
- Respite/family resource centers.
- Transportation.

The list(s) must include the description of services offered, name of agency, address, telephone number, contact person, and any costs associated with the services.

PERFORMANCE MEASUREMENT

I.J. A current list of appropriate community resources - including, but not limited to, the services and agencies stated in the guidelines - and addresses, telephone numbers, and any associated costs is on file.

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(Continued)

GUIDELINE	PERFORMANCE MEASUREMENT
I.K. Establish working relationships (for the purpose of referrals) with key community agencies, social services providers, HMOs, and Medicaid primary care providers. If possible, develop written agreements that address the specific procedures to be followed for making referrals and for obtaining information on the outcome of the referrals from these agencies and providers. Ensure that staff is aware of these agreements. Medicaid HMOs are required to sign a Memorandum of Understanding (MOU) with all prenatal care coordination providers in their service area. The MOUs address the provision of services to pregnant women. As appropriate, work with the HMOs to expand the cooperative agreement beyond the postpartum period.	**I.K.** The provider's file includes written agreements or documentation that show that the provider has made good faith efforts to develop effective working relationships with key health and social services providers.
I.L. Establish written procedures regarding the release of recipient-specific information. Recipients may sign a general release of information. However, providers must obtain specific approval to release sensitive information about the recipient.	**I.L.** The provider has written policies regarding the release of recipient-specific information. The policies specifically address the release of sensitive information.

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(Continued)

II. FAMILY QUESTIONNAIRE ADMINISTRATION

The provider must administer the Medicaid-approved assessment tool (the Family Questionnaire) to determine eligibility for the benefit. The assessment tool is designed to identify the recipient's strengths and needs. In addition to the Family Questionnaire, the provider may use any commercial or self-designed form to conduct a more detailed assessment.

All recipients must have a completed copy of the Family Questionnaire in their file.

Note: The Family Questionnaire includes several questions to which the recipient may object. Prior to administering the Family Questionnaire, explain the assessment and care planning process, acknowledge the intrusiveness of some of the questions and explain why you need to ask the questions. If necessary, share your agency's confidentiality policies with the recipient, including who will have access to the information provided.

GUIDELINE
The provider must:

II.A. Administer and score the Family Questionnaire in its entirety unless the recipient objects to a particular question or section, or the information is unavailable.

II.B. Review and finalize the Family Questionnaire in a face-to-face meeting with the recipient. The staff completing the Family Questionnaire must sign and date it. A qualified professional must review and sign all Family Questionnaires completed by paraprofessional staff.

II.C. Inform recipients who score 70 or more points on the Family Questionnaire that they are eligible to receive CCC services.

If the recipient is not interested in receiving services, try to determine the reason. Give the recipient a written copy of the agency's address and telephone number and ask the recipient to call or stop by if she changes her mind.

II.D. Inform recipients who score less than 70 points on the Family Questionnaire that they are not eligible to receive CCC services.

Based on the recipient's identified needs, refer her to other community resources as appropriate. Give the recipient with a written copy of the agency's telephone number and ask her to call or stop by if she has a significant negative change in her family, medical, social, or economic status within six months after the initial assessment.

PERFORMANCE MEASUREMENT

II.A. The recipient's file includes a completed and scored Family Questionnaire. If the questionnaire is not completed in its entirety, there is documentation that explains why.

II.B. The recipient's file includes documentation that the Family Questionnaire was reviewed and finalized in a face-to-face visit. The Family Questionnaire is signed and dated. The recipient's file also includes documentation that a qualified professional reviewed and signed all Family Questionnaires completed by paraprofessional staff.

II.C. The recipient's file documents that the recipient was offered CCC services.

If the recipient is not interested in receiving services, the reason is documented. The file includes documentation that the recipient received a written copy of the provider's address and telephone number and was asked to call if she changes her mind about receiving services.

II.D. The recipient's file includes documentation that the recipient was referred to other community resources as appropriate. The file also documents that the recipient was asked to contact the provider if she has a significant negative change in her family, medical, social, or economic status within six months.

Changes to the Family Questionnaire are legible and clearly identified. The Family Questionnaire is signed and dated.

GUIDELINE (II.D. Cont.)	PERFORMANCE MEASUREMENT
Also, the provider may reassess the recipient if someone, such as a health care professional, a school, or a social worker, refers her back to the provider within six months of the initial assessment. The provider may use the same Family Questionnaire if the reassessment or update is within 12 months of the initial assessment. Changes to the Family Questionnaire must be clearly identified (for example, use of different color ink, cross out old response). Do not erase or totally obliterate the original response. Re-sign and date the Family Questionnaire.	
II.E. Use a new Family Questionnaire for assessments administered after 12 months of the initial assessment.	**II.E.** The recipient's file includes a new Family Questionnaire if more than 12 months have elapsed since the initial assessment.

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(Continued)

III. CARE PLAN DEVELOPMENT

The Family Questionnaire must be completed prior to the development of the care plan. The provider is not required to use a specific care plan format. However, the care plan must be based on the results of the Family Questionnaire.

As appropriate, the activities outlined in the care plan must be aimed at the following:

- Improving family functioning.
- Improving parenting skills and positive parenting outcomes.
- Increasing recipients' understanding of infant and child development.
- Increasing recipients' access to and appropriate use of the health care delivery system.
- Improving employment outcomes.
- Encouraging planned pregnancies.
- Improving future birth outcomes.

GUIDELINE	PERFORMANCE MEASUREMENT
The provider must:	
III.A. Develop a written individualized care plan for each recipient scoring 70 or more points on the Family Questionnaire. Develop only one care plan for each recipient.	**III.A.** The recipient's file includes an individualized care plan if the recipient scored 70 or more points on the Family Questionnaire.
III.B. Include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The recipient and provider who developed the care plan must sign and date the plan.	**III.B.** The recipient's file includes documentation that the recipient and, when appropriate, the recipient's family and other supportive persons actively participated in the development of the care plan. The recipient and provider have signed the care plan.
III.C. Inform the recipient that the care plan can be changed at any time, and as often as necessary. Provide the recipient with information on how to request changes to the care plan, including the name and telephone number of the person to contact to initiate the change.	**III.C.** The recipient's file includes documentation of the stated guideline.
III.D. Ensure that the care plan includes the following: • Identification and prioritization of strengths and problems identified during the initial assessment. • Identification and prioritization of all services to be arranged with the recipient, including the names of the service providers (including health care providers). • A description of the recipient's informal support system, including collaterals, and activities planned to strengthen it if necessary.	**III.D.** The recipient's file includes a care plan that meets the stated guidelines. If necessary, the care plan identifies all of the care coordinators involved with the family, addresses the role of each care coordinator, and addresses the frequency of contacts between the care coordinators.

GUIDELINE (III.D. Cont.)	PERFORMANCE MEASUREMENT
• Appropriate referrals and planned follow up. • Expected outcome of each referral. • Progress or resolution of identified priorities. • Documentation of unmet needs and gaps in service. • Planned frequency, time, and place of contacts with the recipient. • Identification of individuals who participated in the care plan development. • The recipient's responsibility in the plan's implementation. If there are other care coordinators involved with the family, the care plan must: • Identify the role of each care coordinator. • Address any needed collaboration or coordination. • Address, at least every 60 days, the frequency of contacts between the care coordinators. This requirement applies whether or not Medicaid covers the other care coordinator's services. The family's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap. The need for more than one care coordinator in the family must be reassessed every 12 months.	
III.E. At a minimum, review and update the recipient's care plan every 60 days for the first year of the child's life. Thereafter, review and update the care plan at least every 180 days. If necessary, update the recipient's care plan during each visit. All updates to the care plan must be dated and signed or initialed by the provider and the recipient.	**III.E.** The recipient's file includes documentation that the care plan was updated at least every 60 days for the first year of the child's life and reviewed and updated a minimum of every 180 days thereafter. All updates to the care plan are dated and signed or initialed by the provider and the recipient.
III.F. Provide the recipient with the written name and telephone number of: • The person who will provide the ongoing care coordination services. If necessary, introduce the recipient to the care coordinator if he or she is different from the person who administered the assessment and developed the care plan. • The person to contact in urgent situations or as backup when the care coordinator is unavailable.	**III.F.** The recipient's file includes a copy of, or documentation stating that the provider gave to the recipient, written information identifying the name and telephone number of the care coordinator and of the person to contact as backup.

IV. ONGOING CHILD CARE COORDINATION AND MONITORING

All recipients must have a care plan in their file that predates the delivery of ongoing CCC services, except for in urgent situations. In such cases, the provider is required to document the urgent situation. The provider is required to document all recipient and collateral contacts. The documentation must include the following:

- The recipient's name.
- The date of the contact.
- The full name and title of the person who made the contact.
- A clear description of the reason for and nature of the contact.
- The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
- Where or how the contact was made.

Ongoing CCC services must be based on the care plan.

GUIDELINE	PERFORMANCE MEASUREMENT
IV.A. On an ongoing basis, the provider must: • Determine which services identified in the care plan have been or are being delivered. • Determine if the services are adequate for the recipient's needs. • Provide supportive contact to ensure that the recipient is able to access services, is actually receiving services, or is engaging in activities specified in the care plan. • Monitor the recipient and the family's satisfaction with the service. • Ask the recipient to evaluate the quality, relevance, and desirability of the services to which she or her family have been referred. • Identify changes in the family's circumstances that would require an adjustment in the care plan.	**IV.A.** The recipient's file includes documentation that indicates the provider offered ongoing services as stated.
IV.B. Provide the recipient with information on community resources and referrals to other agencies when appropriate. Whenever possible, provide written referrals. Written referrals must include: • The care coordinator's name, address, and telephone number. • The recipient's name. • The date that the referral is made. • The name, address, and telephone number of the agency/provider to which the recipient is being referred. • The reason for the referral.	**IV.B.** The recipient's file indicates that the provider made available information on community resources and provided referrals as appropriate. A copy of all written referrals is maintained (or noted if verbal) in the recipient's file.

GUIDELINE	PERFORMANCE MEASUREMENT
IV.C. When referring the recipient for services, the care coordinator must: • Ensure that the recipient understands the reason and need for the referral. • Inform the recipient of all available options for obtaining the needed service. • Explain any costs involved or limitation in the service. • Assist the recipient in learning how to access the service for which the referral was made, including the appropriate use of contact name, telephone number, and address. • Follow up with the service agency, including appropriate advocacy on behalf of the recipient to ensure that services are provided. Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance.	**IV.C.** The recipient's file includes copies of referrals, consent for release of information, and documentation of the coordinator's follow-up on all referrals with the recipient and the service provider.
IV.D. Ensure that the intensity and frequency of contacts with the recipient corresponds to the level of need and/or risk identified by the Family Questionnaire. For example, schedule frequent face-to-face visits if the family is in crisis, if there is violence in the home, or if the mother is a first-time parent with no support system. If necessary, call or visit the recipient daily or weekly. At a minimum: • Contact (face-to-face or telephone) the recipient every 30 days in the first 6 months. • Make face-to-face contact with the recipient every 60 days during the first year. • Contact (face-to-face or telephone) the recipient every 90 days in subsequent years. Document the reason for less frequent contacts in the recipient's file.	**IV.D.** The recipient's file includes documentation that contacts with the recipient correspond to the level of need/risk and includes the date, time, location, and length of recipient contact, progress and/or resolution of identified problems and signature of a professional reviewer. The recipient's file includes documentation supporting contacts with the recipient that are less frequent than the stated guidelines.

GUIDELINE	PERFORMANCE MEASUREMENT
ACTIVITIES AIMED AT IMPROVING FAMILY FUNCTIONING	**ACTIVITIES AIMED AT IMPROVING FAMILY FUNCTIONING**
The care coordinator must:	
IV.E. Assist the recipient in identifying neighborhood activities and support groups that will enhance family functioning. Follow up with the recipient to determine if participation occurred.	**IV.E.** The recipient's file includes documentation of activities and the groups identified for participation by the recipient and the care coordinator. The file includes documentation of participation.
IV.F. Encourage the recipient to establish safe behaviors. Activities to encourage safe behaviors include, but are not limited to, the following: • Assisting the recipient in obtaining a home safety checklist. • Assisting the recipient in evaluating the risk for injuries in the home and other settings where her children spend a significant amount of time. • Helping the recipient plan changes in the home to establish a safe environment for infants and young children. • Encouraging the recipient to conduct a home safety checklist at each new residence and at least annually. • Assisting the recipient as needed to access safety projects, including properly installed smoke detectors. In the case of rental property, assist the recipient in contacting and following up with the landlord if necessary.	**IV.F.** The recipient's file documents all safety-related assistance, including deficiencies found and plans for corrective action. The file also includes documentation of referrals and related follow-up, including any contact with the recipient's landlord.
IV.G. Assist the recipient in obtaining services to learn about and improve life skills, such as: • Consumer skills, including self-advocacy. • Home and money management, including resources for food, food budgeting, preparation, and storage. • Arranging appropriate and inexpensive family leisure activities.	**IV.G.** The recipient's file includes documentation relative to assisting the recipient in obtaining services to learn about and improve life skills, and all referrals and follow-up.

GUIDELINE	PERFORMANCE MEASUREMENT
ACTIVITIES AIMED AT IMPROVING PARENTING SKILLS AND POSITIVE PARENTING OUTCOMES	**ACTIVITIES AIMED AT IMPROVING PARENTING SKILLS AND POSITIVE PARENTING OUTCOMES**
The provider must establish written protocols for: • Assessing potential/actual child abuse. • Meeting the legal reporting requirements. • The frequency and intensity of monitoring those families identified at risk for abuse.	The recipient's file includes documentation relative to assisting the recipient in obtaining services to learn about and improve life skills and all referrals and follow-up.
The provider must:	
IV.H. Assess the recipient's interpersonal relationships with the infant/child, her partner, and other family members living in the home. The assessment should include, but is not limited to, the recipient's strengths, weaknesses, support system, social environment, stresses, attitude toward the infant/other children, and past experiences with parenting. Refer the recipient for psychosocial services as appropriate. Ensure timely follow-up.	**IV.H.** The recipient's file includes documentation of assessment, problems noted, and referrals made. The file also includes documentation that the care coordinator followed up with the recipient to confirm that the referrals resulted in appointments.
IV.I. Immediately refer the recipient to a qualified professional if the recipient exhibits behavior that may be dangerous to herself or others. Situations requiring immediate referral must be documented in the recipient's file. Specifically document all known referrals to the child welfare system. Within 24 hours of making the referral, confirm that the recipient has made the appointment(s).	**IV.I.** The recipient's file includes documentation of the specific concern or behavior noted, a copy of referrals made (including specific documentation of known referrals to the child welfare system), and outcome of the referrals. The file also includes documentation that, within 24 hours of making the referral, the care coordinator followed up with the recipient to confirm that the referrals resulted in appointments.
IV.J. As appropriate, provide referrals for parenting education that will: • Educate the recipient about normal developmental milestones. • Help the recipient identify the early signs associated with potential developmental delays and/or emotional problems. • Help the recipient develop positive parenting skills. • Help the recipient provide a nurturing environment for her children. • Help the recipient develop the necessary skills to become a self-advocate and to advocate on her children's behalf.	**IV.J.** The recipient's file includes documentation of referral for parenting education and all contacts with parenting support services. Changes in parenting behavior are documented in the recipient's file.

GUIDELINE (IV.J. Cont.)	PERFORMANCE MEASUREMENT
Monitor type and frequency of parenting support and training. Follow up with the recipient to determine if she is receiving services.	
ACTIVITIES AIMED AT INCREASING RECIPIENTS' UNDERSTANDING OF INFANT/ CHILD DEVELOPMENT	**ACTIVITIES AIMED AT INCREASING RECIPIENTS' UNDERSTANDING OF INFANT/ CHILD DEVELOPMENT**
The care coordinator must:	
IV.K. Assess the recipient's knowledge and understanding about nutrition and infant/child feeding practices and how these factors affect growth and development. This screening is required to begin with the first visit and is required to be followed up with periodic assessments. Refer the recipient to a qualified professional if knowledge deficiencies are found in any of the following topics: • Infant's hunger/fullness cues. • Infant nutrition and appropriate feeding practices. • Successful breastfeeding. • Food and/or formula preparation and storage. • Meal pattern and feeding practices for infants, toddlers, and preschool children. • Dangers of eating non-food substances (pica) and of folk remedies. • Nutrition to reduce the effects of lead poisoning (e.g., calcium-rich and iron-rich foods). Ensure timely follow-up on referrals.	**IV.K.** The recipient's file includes documentation of the assessment, information provided to the recipient, and any follow-up done by the care coordinator relative to the recipient's increased understanding of infant/child development.
IV.L. Assess the recipient's knowledge regarding basic child health and development. Refer the recipient to a qualified professional if deficiencies are found in any of the following areas: • Bathing, skin care, diaper rash. • Normal growth and development, including developmental milestones (for example, toilet training), and vision, hearing, speech, and motor development. • Child nurturing and stimulation. • Effects of secondhand smoke on infant/ child health.	**IV.L.** The recipient's file includes documentation of identified health education needs, the information provided, referrals given, and follow-up.

GUIDELINE (IV.L. Cont.)	PERFORMANCE MEASUREMENT
• Taking temperature, treatment of nausea, vomiting, fever, or dehydration. • Injury prevention and safety, including use of car seats, falls, choking, sleep positions, and poisoning. Ensure timely follow-up on referrals.	
IV.M. Assess the recipient's knowledge of the steps involved in obtaining appropriate and reliable child care. Provide information or refer the recipient for assistance if deficiencies are found in the following areas: • Knowledge regarding available resources for checking provider references. • Evaluating child care settings for safety. • Obtaining financial assistance for child care. • Appropriate monitoring of the child care provider. • Reporting suspected child abuse or neglect by the child care provider.	**IV.M.** The recipient's file includes documentation of the assessment, information provided, referrals given, and follow-up.
ACTIVITIES AIMED AT INCREASING ACCESS TO AND USE OF PRIMARY HEALTH CARE SERVICES The care coordinator must: **IV.N.** Assist the recipient in accessing and appropriately using the health care delivery system. For example, ensure that the recipient: • Can identify the family's primary care physician(s) or clinic and HMO if appropriate. • Has health care providers' telephone numbers and addresses and knows where to find them. • Knows the proper procedures for obtaining medical information or health care after hours. • Understands how to obtain speciality care, for example, mental health/substance abuse (alcohol and other drug abuse) treatment or speech therapy. • Knows when to use the hospital emergency room.	**ACTIVITIES AIMED AT INCREASING ACCESS TO AND USE OF PRIMARY HEALTH CARE SERVICES** **IV.N.** The recipient's file includes documentation of recipient's knowledge, deficiencies, and information provided as stated in the guidelines.

GUIDELINE (IV.N. Cont.)	PERFORMANCE MEASUREMENT
• Knows how to schedule, reschedule, and cancel appointments. Assist the recipient in obtaining information as appropriate.	
IV.O. Assess the recipient's awareness of the importance of timely immunizations and regular dental and well-child checkups (HealthCheck). Determine the recipient's compliance with the visit schedules for these services. Assist the recipient in obtaining services as appropriate. Reassess the recipient's compliance with the recommended schedules on an ongoing basis.	**IV.O.** The recipient's file includes documentation of the child's immunization, dental, and HealthCheck compliance status. If deficiencies are found, file includes documentation of referrals, appointments made, and follow up to bring family into compliance.
IV.P. Assess the recipient's awareness of the effects of lead poisoning. Assist the recipient as needed to receive recommended blood lead tests and necessary follow up services.	**IV.P.** The recipient's file includes dates and results of lead tests and follow up for any elevated lead test results.
IV.Q. Refer the recipient for additional support, assistance, and specific training to learn how to care for her child if the child is identified as having a birth defect or a special health care need.	**IV.Q.** The recipient's file includes documentation of the identified problem, referrals given, and follow up.
ACTIVITIES AIMED AT IMPROVING EMPLOYMENT OUTCOMES	**ACTIVITIES AIMED AT IMPROVING EMPLOYMENT OUTCOMES**
IV.R. Help the recipient identify employment goals and barriers to obtaining or maintaining employment. Address the following areas with the recipient: • Transportation problems. • Medical problems of family members. • Child day care and/or health care needs. • Appropriate conflict/grievance procedures. • Job preparation and interview skills. • Appropriate attire. • Job training or retraining needs. • Educational needs. Assist the recipient in obtaining services as appropriate.	**IV.R.** Recipient's file includes documentation of employment status and/or barriers to employment and, as appropriate, indicates referral to the appropriate agency for assistance in obtaining necessary services to support employment.

GUIDELINE	PERFORMANCE MEASUREMENT
ACTIVITIES AIMED AT ENCOURAGING PLANNED PREGNANCIES	**ACTIVITIES AIMED AT ENCOURAGING PLANNED PREGNANCIES**
IV.S. Assess the recipient's self-esteem, assertiveness, and empowerment regarding family planning decisions. Help the recipient determine what referrals or other actions are needed.	**IV.S.** The recipient's file includes documentation of referral, information provided, and any follow-up.
IV.T. Assess the recipient's knowledge of the following: • Family planning practices/methods. • Prevention of sexually transmitted diseases. • Continuity of basic primary and reproductive health care, including the need for mammograms and routine pap smears. Provide the recipient with necessary referrals, and ensure timely and appropriate follow-up on all referrals.	**IV.T.** The recipient's file includes written documentation of assessment and referrals related to family planning and basic health issues of the mother.
ACTIVITIES AIMED AT IMPROVING FUTURE BIRTH OUTCOMES	**ACTIVITIES AIMED AT IMPROVING FUTURE BIRTH OUTCOMES**
IV.U. Refer the recipient to the WIC program, if appropriate. Ensure timely follow up.	**IV.U.** The recipient's file includes documentation of a WIC referral and appropriate follow-up.
IV.V. Assess the recipient's knowledge of the need for early and ongoing prenatal care, the importance of not smoking during pregnancy, and the importance of planned pregnancies. Provide the recipient with necessary referrals, and ensure timely and appropriate follow-up on all referrals.	**IV.V.** The recipient's file includes documentation of the assessment and any referrals made.